Part B Insider (Multispecialty) Coding Alert

Reader Question: Here's the Scoop on Timely Filing Extensions

Question: At our practice, we are very careful to submit our Medicare fee-for-service (FFS) claims within the allotted time frame. However, during the pandemic, we've had a few late issues that have caused us to lose critical income. Are there any exceptions to the timely filing requirements?

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Answer: There's nothing more frustrating than dealing with late claims, and COVID-19 has definitely impacted many a provider's ability to meet Medicare's 12-month timely filing window.

Reminder: Timely filing means that your practice submits a Medicare FFS claim within 12 months. Ever since the Affordable Care Act (ACA) went into effect, claims must be filed within one calendar year after the date of service (DOS). Medicare will deny your claim if it arrives after the deadline date, so your practice has to stay on top of claims.

However, as is often the case with Medicare, there are a few exceptions to the rule. In fact, the Centers for Medicare & Medicaid Services (CMS) offers FFS providers four exceptions in which they can request an extension on the time limit for their claims. Those include the following:

1. Administrative error: If CMS identifies an error by an employee, on the part of the MAC, or the Department of Health and Human Services (HHS), then you'll be granted a six-month timely filing extension "following the month in which you or the beneficiary received notice that an error or misrepresentation was corrected," explains Part B MAC Novitas Solutions in online guidance.

2. Retroactive Medicare entitlement: When a provider or beneficiary is notified of a Medicare entitlement that is "retroactive to or before the date the service was furnished," a six-month timely filing extension similar to the rules of an administrative error are given, according to Part B MAC Palmetto GBA's online materials.

3. Retroactive Medicare entitlement involving state Medicaid agencies: If "a state Medicaid agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary," then your timely filing is extended six months from when the state Medicaid agency recovered the funds, Palmetto GBA indicates.

4. MA or PACE retroactive disenrollment: This exception is the most involved and is available only when a beneficiary who is enrolled in a Medicare Advantage (MA) plan or Program of All-inclusive Care for the Elderly (PACE) provider organization becomes disenrolled - and the MA plan or PACE organization then recoups their payments. If this occurs six months after the DOS, an exception is possible.

Documentation is key to qualifying for this exception as you must prove the beneficiary's prior enrollment in the MA plan or PACE organization, Novitas Solutions says. The documentation must also show that "you were notified that the beneficiary is no longer enrolled in the MA plan or PACE; the effective date of the disenrollment; and the MA plan or PACE recouped money from you for services rendered to the beneficiary," the Part B MAC advises.

Private payer rules: Not all insurers follow the 12-month limit. Some private insurers will allow you to report your claim for just 60 days after the DOS, while others give you more than a year to submit your claim.

Therefore, you should get to know the filing deadlines of each insurer you bill. Perhaps the easiest way to keep track of multiple payer timely filing rules is to make a chart (such as a spreadsheet) that lists each insurance company's timely filing limit. If you do have a backlog of claims in your office, separate them out by insurance company so you can use your chart to quickly identify the payer with the shortest limit and work on those claims first.